Member Handbook

Effective January 1, 2014

Contents

Welcome

Thank you for choosing Blue Cross Blue Shield of Michigan. We're providing you and your family with this *Member Handbook* to help you get the most from your health plan. As a well-informed member, you'll have the confidence and security of knowing that health care coverage is available when you need it.

This handbook gives you an overview of your health care coverage. For a complete description of your coverage, log in as a member at **bcbsm.com**. Click on the *Manage My Plan* tab, then click *Coverage*.

Please take time to read this handbook and become familiar with your health care coverage. You can also find detailed information on our website, **bcbsm.com**.

If you have technical difficulties, please call Web Support at 1-888-417-3479.

If you don't have online access, call the Customer Service number on the back of your Blue Cross ID card.

The information in this handbook is a summary of your health care benefits. It is not a contract. This summary may not reflect additional limitations or exclusions that apply to covered services or the most recent updates to BCBSM certificates, riders, plan modifications or changes to your coverage. Please call the Customer Service phone number printed on the back of your ID card if you have additional questions about your health care benefits.

Your BCBSM ID card

This section provides information on using your BCBSM member ID card.

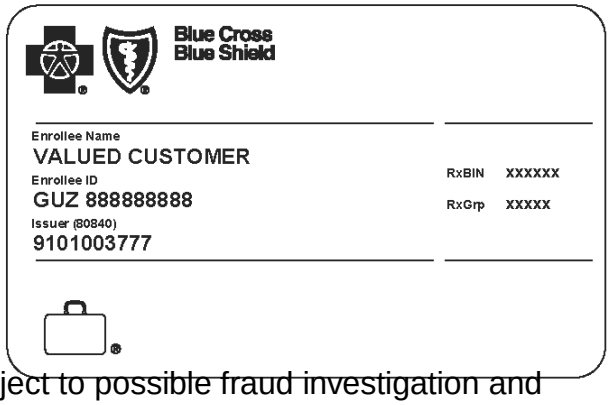
Once enrolled, you'll receive an ID card. All cards will show the contract holder's name, even those issued to dependents.

Enrollee ID: The subscriber's assigned contract number with BCBSM

Issuer: Identifies you as a Michigan BCBS member to out-of-state providers

Enrollee name: The subscriber's name as it appears on our membership records

Group number: A unique five-digit group number identifying your health care plan



About your ID card

Only you and your eligible dependents may use the cards issued for your contract. Lending your card is illegal and subject to possible fraud investigation and termination of coverage.

Call us if your card is lost or stolen. Your provider can call us to verify coverage until you receive your new cards. Unless you request a replacement card, you'll receive new ID cards only when there's a change in your benefit plan.

If you need additional ID cards, you can order them on **bcbsm.com** or by calling the Customer Service number on the back of your Blue Cross ID card.

Discounts for members

With our exclusive Healthy Blue Xtras^{SM} program, members can find special discounts and trusted health and wellness resources. Members will score big savings and special offers on a variety of healthy products and services from companies across Michigan, as well as from nationwide businesses, through our Blue 365^{SM} savings program. Visit **bcbsm.com** and click on *Discount Services* under the *Health and Wellness* tab to find great discounts. Then, just show your Blues ID card to save.

Choosing your provider

Looking for a doctor, hospital or other health care professional

Visit **bcbsm.com** and click *Find a Doctor*.

To help you find the health care provider you need, you can:

- Enter searchable criteria, including gender, extended office hours, secondary languages spoken, hospital affiliation, board certification, medical specialty, patient-centered medical home or Blue Distinction Center® designation.
- Compare providers easily, up to six doctors or facilities side-by-side using selected criteria.
- Read a review of a doctor.
- Print the list.
- Find out-of-state doctors.
- Get cost-estimates by researching and comparing for certain

procedures. You can find a network provider for the following services

on our site:

  - Primary care services, such as routine exams or general health issues
  - Specialty care, such as when you need care for a heart condition or need a surgeon
  - Behavioral care and substance abuse services
  - Evening or weekend services
  - Services from a doctor who speaks another language
  - Services located near you

What is a network provider?

A network provider is a physician, hospital or other health care specialist that provides services through our PPO network. PPO stands for “preferred provider organization.” PPO network providers have signed agreements with us to accept our approved amount as payment in full for services covered under your health care plan. Using PPO network providers limits your out-of-pocket costs for covered services to any in-network

deductible, coinsurance and copayments that may be required by your plan.

Special note for parents of students: Dependents attending school away from home must still choose a PPO physician to remain in-network. (See the section on BlueCard.)

Limited network

For certain providers, BCBSM does not have a PPO network. If you receive services from a provider for which there's no PPO network, the service will be covered at the in-network level of benefits. If you're unsure whether or not there is a PPO network for a particular service, please call the Customer Service number on the back of your Blue Cross ID card.

What is an out-of-network provider?

An out-of-network provider is a physician, hospital or other health care specialist that has not signed an agreement to provide services through our PPO network. Your health care plan generally has higher out-of-pocket deductible, coinsurance and copays for services received outside of the PPO network.

Important: Outside of the PPO network, a provider can either be participating or nonparticipating. Participating providers have agreed to accept our approved amount plus your out-of-network deductible, coinsurance and copayment as payment-in-full for covered services.

Nonparticipating providers haven't signed an agreement and can bill you for any differences between their charges and our approved amount.

How providers are paid

How much you pay for services you receive depends on whether you use a network or an out-of-network provider. We'll explain the difference below.

Under your health care program, the payment allowed for covered services is called the Blue Cross Blue Shield of Michigan approved amount. Our approved amount is the lower of the provider's billed charge or the BCBSM-maximum payment level for the covered service. Any deductible, coinsurance or copays required by your health care plan are subtracted from the approved amount before we make our payment.

PPO network providers — BCBSM sends payment directly to network providers. Because of their signed agreement with BCBSM, network providers will accept this payment as payment in full for covered services. You're only responsible for any in-network deductible, coinsurance or copays that may be required by your health care plan.

Out-of-network providers — If you choose to go out of network, remember that not all services may be covered out of network. That's why it's important to verify that the service is covered by calling the Customer Service phone number on the back of your

ID card.

When using out-of-network providers, you also need to find out if the provider is participating or nonparticipating with BCBSM. Here's why this is important:

Participating providers — BCBSM sends payment directly to participating providers. Because of their signed agreement with BCBSM, participating providers will accept this payment as payment in full for covered services. You're responsible only for any out-of-network deductibles, coinsurance or copays required by your health plan.

Nonparticipating physicians and other professional providers — BCBSM sends payment directly to you, and it's your responsibility to pay the provider. Because BCBSM's payment to you may be less than the provider's charge, you may also have to pay the provider the difference between our payment and the provider's charge. This would be in addition to any out-of-network deductible, coinsurance or copays required by your health plan.

Nonparticipating hospitals, facilities and alternatives to hospital care providers — BCBSM's payment for services received at nonparticipating hospitals is very limited and covers only those services required to treat accidental injuries or medical emergencies. This means that you'll pay most of the charges yourself, which could make your bill a substantial one. Please refer to your health care certificate for a complete explanation of your coverage when services are provided by a nonparticipating hospital or facility.

Preventing fraud

If your provider asks for another form of identification, don't worry. Checking a cardholder's identification is just one way our providers help us protect you against unauthorized use of your card.

You can also help prevent fraud by checking your *Explanation of Benefit Payments* form, or EOB. If you see a discrepancy on your EOB, contact your provider first to see if it is an error. If it's not and you believe it's the result of fraudulent billing or unauthorized use of your card, let us know by calling our Anti-Fraud Hotline at 1-800-482-3787. You can also fill out our online Anti-Fraud form or write to:

Anti-Fraud Unit, Mail Code B759
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226

When reporting fraud, all phone calls and correspondence are confidential.

What you pay out of pocket

For details of the amount of out-of-pocket expenses you pay for medical and behavioral health covered services, view the *Your Benefit Chart* at **bcbsm.com**:

- Log in.
- Click *Manage My Plan.*

If you ’re required to pay for covered services, we’ll reimburse you for our share of the cost. For more information and for a copy of the form, visit **bcbsm.com**:

- Click the *Help* tab.
- Select Plan Documents and Forms*.*
- Click the *Blue Cross Blue Shield General Claim Form.*

Health resources

BlueHealthConnection®

Whether you're looking for ways to improve your lifestyle or manage a chronic condition, BlueHealthConnection has the support system you need — and it begins with a phone call to BlueHealthConnection at 800-775-BLUE (2583).

Working together

Good health depends on certain lifestyle choices we make, including what we eat, how active we are, whether or not we smoke and how we manage a chronic illness such as diabetes or high blood pressure. This is where BlueHealthConnection and our health coaches make a difference.

When you call BlueHealthConnection, an Engagement Center specialist will work with you by phone to help you decide the level of care you need, such as:

- General health education on issues such as smoking-cessation and avoiding the flu
- Symptom management and health coaching if you need general advice about medical concerns and assistance in determining whether to seek care for acute health care problems and where to obtain that care

- Chronic condition management that includes education and coaching in self-management of chronic illnesses

- Case management when you have a medical condition that needs coordination of care

Online health resources

BlueHealthConnection also offers members a private, easy-to-use online resource for personal health and wellness information. The site has a wealth of information on health-related topics and issues to meet your individual health needs, all custom-tailored from Michigan's most trusted name in health care.

Once you log in, click the *Health and Wellness* tab, then *BlueHealthConnection*. Here's what BlueHealthConnection online offers you:

- Health assessment — This questionnaire, developed by doctors and leading health researchers, takes about 20 minutes to complete. It gives you a clear picture of your overall health status and pinpoints your specific health issues and risks. Then you receive a personalized plan to help you improve your health.

- Health information — From health articles to calculator tools, BlueHealthConnection's interactive tools help you participate with your physician in planning your health goals.

- Calculator tools — BlueHealthConnection has interactive tools that can help you learn about general health information and how such factors as body mass affect you and your family's health. You'll find a body mass index calculator, a children's growth calculator and more.

BlueCard program

When traveling outside of Michigan, your coverage travels with you. Through the BlueCard program, you have access to network and participating providers throughout the U.S. and around the world.

And like network and participating providers in Michigan, you won't have to fill out any claim forms or pay up front for the cost of the service unless it's an out-of-pocket cost, such as a deductible, coinsurance or copayment, or a non-covered service.

Here are three steps to make the BlueCard program work for you:

1. In an emergency, go directly to the nearest hospital.

2. Call 1-800-810-BLUE (2583) or search for nearby doctors and hospitals on www.bcbsa.com.

3. When you arrive at the network or participating provider's office or hospital, present your ID card. The doctor or hospital will recognize the suitcase logo and know that you're receiving services under the BlueCard program. This means the doctor or hospital will submit any claim forms and only bill you for any deductible, coinsurance or copay that may be required by your health care plan.

Care out of the U.S.

With our BlueCard program, your coverage also travels with you to foreign countries. When you need care outside of the U.S., follow these six steps:

1. Check your certificate to make sure your international benefits are the same outside of the U.S.

2. To find a provider, call the BlueCard Worldwide Service Center at 1-810- BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization if necessary.

3. In an emergency, go directly to the nearest doctor or hospital, then call the BlueCard Worldwide Service Center if you're hospitalized. For non-emergency inpatient medical care, you must call the BlueCard Worldwide Service Center to arrange access to a BlueCard Worldwide hospital, to locate a doctor or hospital, or if you need medical assistance.

4. If you need to be admitted to a hospital, call your Blue plan for precertification or preauthorization. You can find the phone number on your Blue ID card. Note: This number is different from the phone number listed above.

5. If the BlueCard Worldwide Service Center arranged your hospitalization, the hospital will file the claim for you. You will then pay the hospital for the deductible or copay expenses you normally pay.

6. For outpatient and doctor care or inpatient care not arranged through the BlueCard Worldwide Service Center, you will need to pay the provider and submit a claim form with the original bills to BCBSM. Try to get all itemized receipts, preferably in English.
   We will pay the approved amount for covered services at the rate of exchange in effect on the date of service, minus any deductible, coinsurance or copay that may be required by your plan.

Eligibility, enrollment and membership

Individual plan members: If you have individual coverage, visit **bcbsm.com** for information about eligibility, enrollment and membership.

You can also verify your BCBSM membership records on our website when you log in to your account.

Dependent coverage

Coverage for your dependents is based on the certificates and riders included in your health care plan. For dependent eligibility criteria, refer to your certificates and riders, which are available online. Members without online access can call the Customer Service phone number on the back of the ID card.

Special enrollment periods

If you decline enrollment for yourself and your dependents, including your spouse, because of other health coverage, you may enroll later in this plan if:

- Your other coverage is terminated because of loss of eligibility or if employer contributions for the other coverage are terminated — provided that you request enrollment within 30 days after your other coverage or the contribution toward that coverage ends

- You have a new dependent because of marriage, birth, adoption or placement for adoption — provided you request enrollment within 30 days after the marriage, birth, adoption or placement of adoption

Note: Loss of eligibility includes loss of coverage due to legal separation, death, divorce, termination of employment or reduction of hours. It doesn't include loss of coverage due to failure to pay premiums or termination for cause, such as making a fraudulent claim. If you decline enrollment because you had COBRA, or Consolidated Omnibus Budget Reconciliation Act continuation coverage under another plan, before you may enroll in this plan because of a loss of eligibility, you must continue your COBRA coverage until it's exhausted or until the next open enrollment period.

To request a special enrollment or obtain more information, please call the activation center 1-888-642-2276.

Making membership changes

To request a membership change for one of the reasons listed below, you must complete and return an *Enrollment/Change of Status Form* or call Customer Service. The phone number is shown on the back of your ID card.

- Name or address change
- Adding or removing a dependent
- Cancellation of your contract
- Medicare eligibility and enrollment

To avoid delays in payments or potential coverage problems, please return this form within 30 days of when the event occurs. This is especially important when adding a dependent or removing one from your contract because you can be liable for claims paid in error. For example, in the case of divorce, if you fail to give timely notice, you may be responsible for payments made by BCBSM on behalf of your ex-spouse for services provided subsequent to your divorce date.

Claims information

With the Blues' extensive network of participating providers and our BlueCard program, the only time you may have to file your own claims is if you receive services from a nonparticipating or non-network provider.

Filing a claim

If you receive services from a nonparticipating or non-network provider, ask the provider if he or she will bill BCBSM for the services performed. Most providers, even those who don’t participate with BCBSM, will submit claims to their patients' insurance companies when asked.

If your provider won’t bill BCBSM for you, follow these steps:

- Ask the provider for an itemized statement or a receipt with the following information:
  - Name and address of provider
  - Full name of patient
  - Date of service
  - Provider's charge

  - Diagnosis and type of service

- Make a copy of all items for your files, and send the originals to us along with the claim form. It's important that you file claims promptly because most services have claims filing limitations. To find the form, visit **bcbsm.com**:
  - Click the *Help* tab
  - Select *Plan Documents and Forms*
  - Click the *Blue Cross Blue Shield General Claim Form*

Note: If you receive care out of the country, try to get all receipts itemized in English. Cash register receipts, canceled checks, or money order stubs may accompany your itemized receipts, but may not substitute for an itemized statement.

When payment is made, it will be made directly to the subscriber.

Your *Explanation of Benefits*

After we process claims for services you receive, we send you an *Explanation of Benefits*, which we also refer to as an EOB. The EOB is not a bill. It helps you understand how your benefits were paid. At the top of the EOB, you'll find Blue Cross Blue Shield Customer Service numbers and an address to use for questions.

Receive your *Explanation of Benefits* electronically

Instead of receiving your EOBs in the mail, you can sign up to get your EOBs online. Blue Cross will send you an email to notify you of a new EOB that's been posted. You can view, save or print your EOB statements.

Just visit **bcbsm.com**, log in and click *Manage My Plan*.

Reading your EOB

Briefly, your *Explanation of Benefits* tells you:

- The person who received the services
- The date services were provided ("claims processed from...to...")
- "Summary of Balances" includes the providers of the services and payments, including the amount saved by using network providers.
- "Summary of Deductibles and Copayments" provides your deductible, coinsurance and copayment requirements as well a total of all deductibles,

coinsurances and copayments paid to date.

- "Helpful Information" includes messages and reminders.
- "Detail on Services" summarizes the BCBSM payment and shows your balance.

If you see an error, contact your provider first. If they're unable to correct the error, call the Customer Service number on your EOB.

What if my claim is rejected or denied?

Every effort is made to process your claims promptly and correctly. If your claim for benefits is denied in whole or in part, we'll notify you of the denial in writing. To appeal the denial or payment, you may either call or write to us using the number or address on the back of your BCBSM ID card. Be sure to state the reason for your appeal and furnish us with all information that supports your appeal. We'll review your appeal and respond to you within 60 days after we collect it.

For more information on the appeals process and what you must do, please log in at **bcbsm.com**:

- Select *Manage My Plan*
- Click *Benefits*
- Click the *Appeals* tab

Getting the care you need

Our approval for some services

Some services are eligible for coverage only when your provider obtains approval before giving them. Services requiring approval include select radiology services (CT, CTA, MRI, MRA, QCT bone densitometry, nuclear cardiology, PET, PET and PET/CT fusion, diagnostic CT colonography, CT abdomen and pelvis), inpatient acute care, skilled nursing care, human organ transplants, inpatient mental health care, inpatient substance abuse treatment, self- and physician-administered specialty drugs, applied behavioral analysis and rehabilitation services.

Access to our staff

Blue Cross works with our network providers to improve delivery of health care and to improve outcomes. We want to make sure you're receiving the highest quality care and service and that you receive it promptly. This is called "utilization management." If you have questions or want more information about this process and the approval of care, please call the Customer Service number on the back of your ID card.

Evaluating medical technology

The Medical Policy Administration of Blue Cross Blue Shield of Michigan and the Care Management department of Blue Care Network of Michigan are responsible for evaluating new technologies and the new applications of existing technologies, the development of medical policies related to these technologies and the development of coverage recommendations. This process includes, but isn't limited to these areas for potential new technologies: medical procedures and services, medical devices, surgical procedures, behavioral health procedures and pharmaceuticals.

Emergency care

If you're not sure whether your condition (such as high fever, sharp or unusual pain or minor injury) requires emergency care, but you think it needs prompt attention, it's best to call your doctor or your doctor's after-hours phone number.

You can also visit a network urgent care center for nonemergency conditions such as earaches, colds, flu, minor burns, fever, sprains, sore throats and headaches. For a list of urgent care centers, visit **bcbsm.com**.

If you have an emergency and taking the time to call your doctor may mean permanent damage to your health, seek treatment first. Go to the nearest emergency room or call 911.

After the emergency has passed, your doctor can arrange appropriate follow-up care.

Pain management

BCBSM considers pain management an integral part of a complete disease treatment plan. We provide coverage for the comprehensive evaluation and treatment of diseases, including the management of symptoms such as pain that may be associated with these diseases. Your health care benefits provide for such coverage and are subject to contract limitations.

Some services aren't covered

Experimental services: We don't pay for experimental services. Facility services and physician services, including diagnostic tests related to experimental procedures, are also not payable. Please refer to your certificate for an explanation of how we determine which services are considered experimental. For a list of services not covered by your health plan, log in at **bcbsm.com**. Select *Manage My Plan*

Prescription drug coverage

You can check the drugs we cover under our various pharmacy plans by visiting **bcbsm.com/importantinfo**. Select *Drug lists and pharmacy information*.

Coordination of benefits

Coordination of Benefits, or COB, is how health care carriers coordinate benefits when you are covered by more than one health care plan. Under COB, carriers work together to make sure you receive the maximum benefits available under your health care plans. Your BCBSM health care plan requires that your benefit payments be coordinated with those from another individual or group plan for services that may be payable under both plans.

How COB works

If you're covered by more than one individual or group plan, COB guidelines determine which carrier pays for covered services first.

Your primary plan is responsible for paying first. This plan must provide you with the maximum benefits available to you under that plan.

Your secondary plan is responsible for paying after your primary plan has processed the claim.

Note: To the extent that the services covered under your health care plan are also covered and payable under another individual or group health care plan, we'll combine our payment with that of the other plan to pay the maximum amount we would routinely pay for the covered services.

Filing secondary COB claims

Ask your health care provider to submit claims to your primary carrier first. If a balance remains after the primary carrier has paid the claim, you or the provider can then submit the claim along with the primary carrier's payment statement to BCBSM.

Updating COB information is your responsibility

You can avoid delays in processing your claims by keeping your COB information up to date. You can view your current COB information online at **bcbsm.com**.

If you need to change the information we have on record, immediately notify BCBSM. We may also periodically ask you to update your COB information through a letter of inquiry. You can help us serve you better by quickly responding to the letter.

Subrogation

Your contract with Blue Cross Blue Shield of Michigan includes a provision called "subrogation." If you file a lawsuit or an insurance claim, or if there's a settlement, subrogation allows Blue Cross Blue Shield of Michigan to hold a party that caused an

injury or condition to be responsible for payment of the medical expenses related to the injury. For more information or for a copy of the form:

- Visit **bcbsm.com**.
- Click the *Help* tab.
- Select *Plan Documents and Forms.*

Send us the completed form.

Mailing:

Blue Cross Blue Shield of Michigan
Subrogation Department
232 S. Capitol Ave., L09A
Lansing, MI 48933-1504

Email: SubrogationUnit@bcbsm.com

Phone: 1-866-296-3975

Fax: 1-877-257-2012

Please remember that, if you hire an attorney to represent you in such a situation, you should always have your attorney call Blue Cross at 1-866-296-3975.

Customer service

To call us, please use the phone number printed on the back of your ID card. You can also find this number on your *Explanation of Benefit Payments* or EOB.

Our Customer Service hours are from 8 a.m. to 8 p.m., Monday through Friday, and from 10 a.m. to 4 p.m. Saturday.

You can visit **bcbsm.com** to see if there's a walk-in customer service center near you for personal, face-to-face service. Walk-in customer service center hours are from 8:30 a.m. to 5 p.m., Monday through Friday.

Our goal is to provide excellent service. When you call, please be ready to tell us your contract number. If you're inquiring about a claim, we'll also need the following information:

- Patient's name
- Provider's name (hospital, doctor, laboratory, other)
- Date of service and type of service (surgery, office call, X-ray, other)

- Provider's charges

Please remember, Blue Cross Blue Shield of Michigan follows strict privacy policies in accordance with state and federal law. You'll find our *Notice of Privacy Practices* at **bcbsm.com**.

Language translation services

When you call the Customer Service number, you can request language assistance.

If you have a complaint

Blue Cross Blue Shield of Michigan and your primary care physician are interested in your satisfaction with the services you receive as a member. If you have a problem or concern about your care, we encourage you to first discuss that concern with your primary care physician. Often your primary care physician o9r PCP can correct the problem to your satisfaction. You're always welcome to call our Customer Service department with any questions or problems you may have.

To assist Blue Cross Blue Shield of Michigan in our investigation, you may submit any information or evidence concerning the complaint at any point during the complaint process. You may file a complaint or appeal verbally or in writing. Complaints won't be accepted via email. There are no fees or costs associated with filing a complaint. All complaints can be submitted by calling Customer Service or by sending mail to the address listed below.

Customer Service: Use the phone number on the back of your Blue Cross Blue Shield of Michigan ID card.

Mailing address:

BCBSM Complaints — Mail Code 2004
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226

Fax: 1-877-348-2210